

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/04/2015
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NAME OF PROVIDER OR SUPPLIER COUNTRY WOOD # 4	STREET ADDRESS, CITY, STATE, ZIP CODE 167 SALEEN DRIVE WILLOW SPRING, NC 27592
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C 000	Initial Comments	C 000		
C 171	<p>10A NCAC 13G .0504(a) Competency Validation For Licensed Health</p> <p>10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks</p> <p>(a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 1 of 2 sampled non-licensed staff (Staff B) had been competency validated for the Licensed Health Professional Support task of collecting and testing of fingerstick blood samples.</p> <p>The findings are:</p> <p>Review of the staff record for Staff B, Administrator on 12/03/2015 revealed: -Staff B passed the Administrator exam on 10/07/2010. -There was no hire date listed. -No documentation of LHPS competency validation for the LHPS task of collecting and testing of fingerstick blood samples.</p>	C 171		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 171	<p>Continued From page 1</p> <p>Review of Resident #1's current FL-2 dated 10/27/2015 revealed Resident #1 had a physicians order for fingerstick blood sugar checks twice daily.</p> <p>Review of Resident #1's Medication Administration Records (MARs) for November 2015 revealed Staff B initialed the MAR at 8am and 8pm daily from 11/01/2015 through 11/26/2015 for fingerstick blood sugar checks.</p> <p>Interview with Staff B on 12/03/2015 at 9:40am revealed:</p> <ul style="list-style-type: none"> -Staff B had checked Resident #1's fingerstick blood sugar twice daily since 10/27/2015 until another staff was hired and validated by the Registered Nurse to perform the task at the facility. -Staff B's LHPS validation for collecting and testing of fingerstick blood samples had been done by the Registered Nurse. -Staff B, Administrator was not able to find a copy of the LHPS validation for collecting and testing fingerstick blood samples that had been completed prior to Staff B performing the task for Resident #1. -The Registered Nurse was going to try to fax a copy of the LHPS validation for Staff B to the facility. <p>No additional information was provided during the survey for LHPS validation of Staff B for fingerstick blood sugar sampling.</p>	C 171		
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and</p>	C 202		

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C 202	<p>Continued From page 2</p> <p>Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 residents (Resident #3) sampled were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL-2 dated 10/01/2015 revealed diagnoses of bipolar disorder, hypertension, gastroesophageal reflux disease, and osteoarthritis.</p> <p>Interview with Resident #3 on 12/03/2015 at 8:55am revealed: -Resident #3 transferred to the facility from another facility. -Resident #3 had been at the current facility for about one month.</p> <p>Review of Resident #3's record revealed: -There was documentation for a negative tuberculosis (TB) skin test reading on 08/18/2013. -There was no date the TB skin test was placed. -There was no documentation of any other TB</p>	C 202		
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C 202	Continued From page 3 skin test. Interview with the Administrator/Owner on 12/03/2015 at 2:40pm revealed: -There should be documentation of a 2-step TB skin test in Resident #3's record if completed. -The Administrator thought Resident #3 had a second step TB skin test completed. -The Administrator remembered there was a shortage of tuberculin serum at one time and the facility probably did not follow up in getting Resident #3's TB skin testing completed. -The Administrator was responsible for ensuring 2-step TB skin testing was completed. -The facility would probably be getting TB skin testing completed for the resident today (12/03/2015).	C 202		
C 269	10A NCAC 13G .0904 (c-6) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (6) Menus for all therapeutic diets shall be planned or reviewed by a registered dietitian. The facility shall maintain verification of the registered dietitian's approval of the therapeutic diets which shall include an original signature by the registered dietitian and the registration number of the dietitian. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure menus for 1 of 2 therapeutic diets were planned by a registered	C 269		

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C 269	<p>Continued From page 4</p> <p>dietician and available for staff guidance for 2 of 3 residents (Residents #1 and #2) sampled with physician ordered reduced concentrated sweets (RCS) diet.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 10/27/2015 revealed: -Diagnoses included seizure disorder, anemia, hypertension, history of deep vein thrombosis, and diabetes mellitus. -A diet order for a reduced concentrated sweets (RCS) diet.</p> <p>Interview with the Live-in Supervisor on 12/03/2015 at 9:45am. -Her duties at the facility included preparing meals for the residents. -There was no menu posted in the facility that she was aware of. -She prepared meals according to "whatever I have." -All the residents at the facility was on a regular diet. -Resident #1 was diabetic but was on a regular diet.</p> <p>Interview with the Administrator/Owner on 12/03/2015 at 1:50pm revealed: -There was no diet list posted in the facility. -The facility staff did not give the residents sweets or sugar. -There was a resident at the facility on a reduced concentrated sweets diet. -The Administrator/Owner had been told once at another facility that the facility did not have to have a dietician prepared menu for that facility and thought it was the same for this facility, but had not been told that about this facility.</p>	C 269		

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C 269	<p>Continued From page 5</p> <ul style="list-style-type: none"> -The facility used a regular diet menu to prepare meals for the residents. -The Administrator/Owner would have to get a dietician prepared menu for a reduced concentrated sweets diet. <p>Interview with the Live-in Supervisor on 12/04/2015 at 9:15am revealed:</p> <ul style="list-style-type: none"> -Resident #1 should be on a reduced concentrated sweets (RCS) diet if going by the FL-2 diet order. -Resident #1 was served unsweetened desserts. -Resident #1 was given unsweetened tea when tea was served. -The Live-in Supervisor had not had a menu for a RCS diet since she had been employed at the facility. -The Administrator/Owner told her on 12/03/2015 that she (Administrator/Owner) would have to get a menu for RCS. -Resident #1's fingerstick blood sugar was checked every morning and evening. -Resident #1 was administered insulin every night at bedtime. <p>Review of documented fingerstick blood sugars for Resident #1 revealed for October 2015 to present (12/04/2015), Resident #1's fingerstick blood sugar results ranged from 79 to 274. Resident #1 was out of the facility for the lunch meal on 12/04/2015.</p> <p>Review of the menu posted in the facility on 12/04/2015 revealed the only menu prepared by the dietician was for a regular diet.</p> <p>2. Review of Resident #2's current FL-2 dated 10/27/2015 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included mental retardation, hypertension, schizophrenia, and diabetes 	C 269		

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C 269	<p>Continued From page 6</p> <p>mellitus type II. -A diet order for a reduced concentrated sweets (RCS) diet.</p> <p>Interview with the Live-in Supervisor on 12/03/2015 at 9:45am revealed: -Her duties at the facility included preparing meals for the residents. -There was no menu posted in the facility that she was aware of. -She prepared meals according to "whatever I have." -All the residents at the facility was on a regular diet.</p> <p>Interview with the Administrator/Owner on 12/03/2015 at 1:50pm revealed: -There was no diet list posted in the facility. -The facility staff did not give the residents sweets or sugar. -There was a resident at the facility on a reduced concentrated sweets diet. -The Administrator/Owner had been told once at another facility that the facility did not have to have a dietician prepared menu for that facility and thought it was the same for this facility, but had not been told that about this facility. -The facility used a regular diet menu to prepare meals for the residents. -The Administrator/Owner would have to get a dietician prepared menu for a reduced concentrated sweets diet.</p> <p>Review of documented fingerstick blood sugars for Resident #2 revealed for December 2015 Resident #2's fingerstick blood sugar results ranged from 120 to 132.</p> <p>Interview with Resident #2 on 12/03/2015 at 9:05am revealed:</p>	C 269		

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C 269	<p>Continued From page 7</p> <ul style="list-style-type: none"> -Resident #2 did not know if she was diabetic or not. -Resident #2's meals were prepared by staff at the facility. -Resident #2 attended a day program everyday. -Resident #2's lunch was prepared by staff at the facility and the resident took her lunch with her to the day program. -Resident #2 did not know what was in her sack lunch. <p>Review of the menu posted in the facility on 12/04/2015 revealed the only menu prepared by the dietician was for a regular diet.</p>	C 269		